House Bill 1351

By: Representative Knox of the 24th

A BILL TO BE ENTITLED

AN ACT

To amend Chapter 29A of Title 33 of the Official Code of Georgia Annotated, relating to individual health insurance coverage, so as to provide for changes to definitions; to change participation requirements in the health insurance assignment system; to change participation requirements in the health benefits assignment system; to provide for the Commissioner to file new plans; to provide for the Commissioner to conduct an audit of product offerings in the individual health insurance market; to provide for exclusion of coverage period for preexisting conditions; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Chapter 29A of Title 33 of the Official Code of Georgia Annotated, relating to individual health insurance coverage, is amended by revising Article 1, relating to availability and the assignment system, as follows:

"ARTICLE 1

33-29A-1.

(a) It is the intention of this chapter together with Code Section 33-24-21.1 to provide an acceptable alternative mechanism for the availability of individual health insurance coverage, as contemplated by Section 2741 of the federal Public Health Service Act, 42 U.S.C.A. Section 300gg-41. This chapter shall be construed and administered so as accomplish such intention.

(b) Any reference in this chapter to any federal statute shall refer to that federal statute as it existed on January 1, 1997, including its amendment by the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191.

33-29A-2.

(a) As used in this chapter, the terms:

(1) 'Creditable coverage' and 'eligible individual' have the same meaning as specified in Sections 270l and 2741 of the federal Public Health Service Act, 42 U.S.C.A. Sections 300gg and 300gg-41 except that a person shall not be an eligible individual under this chapter if such person is eligible for or has declined any continuation or conversion coverage or has terminated any such coverage prior to its exhaustion in the last six months, but such person shall be deemed eligible if he or she has been declined twice attempting to obtain individual health insurance in the same period of time.

(2) 'Health insurance issuer' and 'health maintenance organization' have the same meaning as specified in Section 2791 of the federal Public Health Service Act, 42 U.S.C.A. Section 300gg-92.

(3) 'Health insurer' means any health insurance issuer which is not a managed care organization.

(4) 'Managed care organization' means a health maintenance organization or a nonprofit health care corporation.

(b) Any other term which is used in this chapter and which is also defined in Section 2791 of the federal Public Health Service Act, 42 U.S.C.A. Section 300gg-92, and not otherwise defined in this chapter shall have the same meaning specified in said Section 2791.

33-29A-3.

Each health insurer and managed care corporation which is licensed to and does offer health insurance coverage ~~in the individual market~~ in this state shall as a condition of such licensure agree to participation in its respective assignment system provided by this chapter. This Code section shall not apply to an entity which offers only excepted benefits as specified in Section 2791(c) of the federal Public Health Service Act, 42 U.S.C.A. Section 300gg-91(c).

33-29A-4.

(a) Each eligible individual in this state whose most recent creditable coverage was provided by an entity other than a managed care organization shall be entitled to participate in the Georgia Health Insurance Assignment System (sometimes referred to as GHIAS in this chapter) created pursuant to this Code section. Each eligible individual in this state whose most recent creditable coverage was provided by a managed care organization shall be entitled to participate in the Georgia Health Benefits Assignment System created pursuant to Code Section 33-29A-5. Each eligible individual in this state who has been uninsured for a period of 12 months or more shall be entitled to elect to participate in the

Georgia Health Insurance Assignment System or in the Georgia Health Benefits Assignment System.

(b) The Commissioner shall develop the GHIAS system which shall provide for the equitable assignment of eligible individuals who are entitled to and desirous of participating in the system to health insurers offering coverage in the individual market in the state. Such assignment shall be based primarily on the pro rata volume of ~~individual~~ health insurance business done in this state by each such health insurer. The system may include other factors for equitable assignment, as determined to be appropriate by the Commissioner, including but not limited to the geographic area or areas in the state normally served by a health insurer.

(c) Upon assignment of an eligible individual to a health insurer, the eligible individual shall have the right to purchase and the health insurer shall have the obligation to sell ~~either of~~ the standard health insurance ~~policies~~ policy provided for in subsection (d) of this Code section at a premium not to exceed the maximum specified in said subsection or as provided for in Code Section 33-29A-8.

(d) The Commissioner shall develop ~~two~~ at least one standard health insurance ~~policies~~ policy to be provided by health insurers to which eligible individuals are assigned pursuant to this Code section. The actuarial value of the benefits under ~~each~~ such coverage shall be at least 85 percent of the average actuarial value of the benefits provided by all individual health insurance coverage issued by all issuers in the state. Except to the extent specifically provided to the contrary in this chapter, all laws of this state relating to the normal provision of such coverage in the individual market shall apply to the provision of such coverage under this chapter. The Commissioner shall fix a maximum premium to be charged for ~~each~~ such standard policy which shall be not more than 150 percent of the average premium which is or would be charged by all issuers in the state for the same or similar coverage issued other than under this Code section, as determined by the Commissioner. The Commissioner may authorize a health insurer to charge a premium in excess of said 150 percent maximum if and only if the insurer demonstrates to the Commissioner that the application of the 150 percent maximum would endanger the financial solvency of that health insurer.

(e) Nothing in this Code section shall be construed to require a health insurer to offer to an eligible individual any coverage other than ~~one of~~ the ~~two~~ standard health insurance ~~plans~~ plan developed under subsection (d) of this Code section, except to the extent required under federal law to offer at least two choices of coverage to an eligible individual. Nothing in this Code section shall be construed to prohibit any insurer from offering to any individual any otherwise lawful coverage.

33-29A-5.

(a) Each eligible individual in this state whose most recent creditable coverage was provided by a managed care organization shall be entitled to participate in the Georgia Health Benefits Assignment System (sometimes referred to as GHBAS in this chapter) created pursuant to this Code section. Each eligible individual in this state whose most recent creditable coverage was provided by an entity other than a managed care organization shall be entitled to participate in the Georgia Health Insurance Assignment System created pursuant to Code Section 33-29A-4. Each eligible individual in this state who has been uninsured for a period of 12 months or more shall be entitled to elect to participate in the Georgia Health Insurance Assignment System or in the Georgia Health Benefits Assignment System.

(b) The Commissioner shall develop the GHBAS system which shall provide for the equitable assignment of eligible individuals who are entitled to and desirous of participating in the system to managed care organizations doing business in the state. Such assignment shall be based primarily on the pro rata volume of ~~individual~~ business done in this state by each such managed care organization and the geographic area or areas in the state normally served by a managed care organization. The system may include other factors for equitable assignment, as determined to be appropriate by the Commissioner. No managed care organization shall be required to provide coverage outside the geographic area or areas normally served by that managed care organization. However, where this geographic limitation makes it impossible to assign to a managed care organization its equitable share of eligible individuals, a managed care organization may be required by the Commissioner to contract for provision of coverage of eligible individuals, as provided for in Code Section 33-29A-6.

(c) Upon assignment of an eligible individual to a managed care organization, the eligible individual shall have the right to purchase and the managed care organization shall have the obligation to sell enrollment in ~~either of~~ the standard health benefit ~~plans~~ plan provided for in subsection (d) of this Code section at a premium not to exceed the maximum specified in said subsection or as provided for in Code Section 33-29A-8.

(d) The Commissioner shall develop ~~two~~ at least one standard health benefit ~~plans~~ plan to be provided by managed care organizations to which eligible individuals are assigned pursuant to this Code section. The actuarial value of the benefits under ~~each~~ such health benefit plan shall be at least 85 percent of the average actuarial value of the benefits provided by all health benefit plans issued in the individual market by all managed care organizations in the state. Except to the extent specifically provided to the contrary in this chapter, all laws of this state relating to the normal provision of such coverage in the individual market shall apply to the provision of such coverage under this chapter. The

Commissioner shall fix a maximum premium to be charged for ~~each~~ such standard health benefit plan which shall be not more than 150 percent of the average premium which is or would be charged by all managed care organizations in the state for the same or similar coverage issued other than under this Code section, as determined by the Commissioner. The Commissioner may authorize a managed care organization to charge a premium in excess of said 150 percent maximum if and only if the managed care organization demonstrates to the Commissioner that the application of the 150 percent maximum would endanger the financial solvency of that managed care organization.

(e) Nothing in this Code section shall be construed to require a managed care organization to offer to an eligible individual any coverage other than ~~one of~~ the ~~two~~ standard health benefit ~~plans~~ plan developed under subsection (d) of this Code section, except to the extent required under federal law to offer at least two choices of coverage to an eligible individual. Nothing in this Code section shall be construed to prohibit any managed care organization from offering to any individual any otherwise lawful coverage.

33-29A-6.

Any combination of one or more health insurers and one or more managed care organizations may contract with each other for the assumption by one or more health insurers of the obligations otherwise imposed by this chapter on one or more managed care organizations. Under any such contract the responsibility for providing the coverage required by this chapter shall be with a health insurer licensed to do business in this state. Where the obligations of a managed care organization are contractually assumed by a health insurer, the assuming health insurer may substitute coverage under a standard policy of health insurance for coverage under a standard health benefit plan, and provision of such substituted coverage shall satisfy the obligation otherwise owed to an affected eligible individual.

33-29A-7.

The Commissioner may impose a moratorium upon the required issuance of coverage by a health insurer or managed care organization, if the Commissioner determines after public notice and hearing that the continuation of such required issuance by that entity will endanger the solvency of that entity.

33-29A-8.

(a) The Commissioner shall adopt rules and regulations for the implementation of this chapter. Notwithstanding any provision of Chapter 2 of this title or any other law to the contrary, such rules and regulations shall be adopted in exact compliance with the

procedures specified in Article 1 of Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act.' In addition to any other materials submitted under subsection (e) of Code Section 50-13-4, there shall be so submitted the full text of the Georgia Health Insurance Assignment System, the Georgia Health Benefits Assignment System, the standard health insurance ~~policies~~ policy provided for in Code Section 33-29A-4, and the standard health benefit ~~plans~~ plan provided for in Code Section 33-29A-5. The Commissioner shall file new plan designs allowed for assignment coverage pursuant to subsection (c) of this Code section no later than January 15, 2009.

(b) The rules and regulations developed by the Commissioner shall include provisions for applications for GHIAS and GHBAS to be submitted by licensed insurance agents and for such agents to be compensated at a commission rate of not less than 3 percent from the premiums received by the issuing health insurer or managed care organization. For purposes of applications for GHIAS and GHBAS, licensed agents shall not be subject to the certificate of authority requirements of Code Section 33-23-26.

(c) The Commissioner shall, by December 31, 2008, conduct an audit of product offerings in the individual health insurance market in order to provide that assignment coverage issued pursuant to this chapter reflects those otherwise available to consumers outside this chapter, including, but not limited to, wellness incentives, consumer directed health plans, disease management programs, and other risk reduction methodologies available through private market insurers in this state. Such plans may be offered by insurers and managed care organizations required to accept assignments under this chapter in lieu of the standard plans provided in subsection (d) of Code Sections 33-29A-4 and 33-29A-5 as long as such plans meet requirements provided under the guidelines of the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, and as long as they are approved for such use by the Commissioner and are offered at rates not exceeding the limits established for the standard plans.

(d) Individuals deemed eligible as a result of being declined for coverage in the individual health insurance market as provided in subsection (a) of Code Section 33-29A-4 shall be subject to a 12 month exclusion of coverage for preexisting conditions that have been treated in the most recent 12 months prior to seeking coverage in the assignment system if such individuals do not have 18 months of continuous prior creditable coverage with no gap in coverage over 120 days."

SECTION 2.

All laws and parts of laws in conflict with this Act are repealed.